CATASTROPHIC LEAVE REQUEST FORM

(Complete and submit to Health Services at Mail Stop 26-0143)

_____	_____	_____
Recipient Employee Name	Emp. No.	Work Phone

_____
Supervisor's Name

I am requesting donated vacation due to the following qualifying event (check one):

[ ] My serious illness, injury, or incapacitating condition.

[ ] Personal hardship due to the serious illness, injury, or incapacitating condition of my spouse, parent, child, sibling, grandparent, or grandchild; in laws or step-relatives in these relationships; or other person residing in my household for whom there is a personal obligation. My signature below signifies that there exists no other reasonable alternative care than my own that would not create a hardship on me.

I authorize [ ] /I do not authorize [ ] release of my name in soliciting donors for this request.

I understand that receipt of any donated vacation is subject to my eligibility and its availability. I also understand that use of donated leave is allowed only during the period of the above-indicated illness or injury and that I will be responsible for promptly notifying Health Services of the termination of such condition. Unused donated leave will be forfeited upon the conclusion of this leave or separation from employment, whichever comes first.

_____	_____
Recipient Employee Signature	Date